OWNERSHIP / CONTROLLING INTEREST AND CONVICTION INFORMATION

To participate in the South Dakota Medical Assistance (Medicaid) Program, completion of this form is required as mandated by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, 42 CFR 455.104 to 106, inclusive, as required under the Social Security Act. Disclosure of the following information will ensure that South Dakota Medical Assistance continues receiving Federal financial participation.

A. Please list the name and address of each person or corporation with a direct or indirect ownership or control interest of 5% or more in the disclosing entity (provider) or in any subcontractor in which the disclosing entity (provider) has direct or indirect ownership of 5% or more.

Name	Address	% Of Interest
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. Are any of the above mentioned persons related to another as a spouse, parent, child, or sibling?
Yes _____ No _____ If yes, please name and show relationship.

Names	Relationship
_____	_____
_____	_____

C. Do any of the persons or corporations with an ownership or control interest have an ownership or control interest of 5% or more in any other disclosing entity (Medicaid provider)? Yes ____ No ____ If yes, please name and show information.

Name	Other Provider Name	% Of Interest
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Please list any person who has an ownership or control interest in the disclosing entity (provider), or is an agent or managing employee of the disclosing entity (provider) who has ever been convicted of a felony:

Name	Conviction/Felony
_____	_____
_____	_____
_____	_____

PROVIDER STATEMENT:

I certify that the information provided on this form is true and correct. I will notify Division of Medical Services Provider Enrollment of any additions/changes to the information.

Provider Name:_____Title: _____
(please print)

Provider Authorized Signature:_____Date: _____